

# Pre-Admission Clinic Referral



Patient Name:

Date of Birth:

Contact phone number:

Surgeon:

Operation:

Date of surgery:

Please indicate the required items that need to be followed up.

FBE, U&E, LFT'S, Creatinine, ECG

Anticoagulants

Cross match

Other

Group and Hold

Does the patient see a cardiologist? Whom?

Does the patient have a permanent pace maker? Type

Comments/Instructions

**Frankston Private Hospital**

24-28 Frankston Flinders Road, Frankston VIC 3199 | Reception: 03 8796 1300 | Fax: 03 8796 1390 | [www.frankstonprivatehospital.com.au](http://www.frankstonprivatehospital.com.au)

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